CALAIM INCENTIVE PAYMENT PROGRAM

Frequently Asked Questions (FAQ)

Introduction

CalAIM is a multi-year Department of Health Care Services' (DHCS) initiative to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program and payment reform across the Medi-Cal program.[1]

The CalAIM Incentive Payment Program is intended to support the implementation and expansion of CalAIM, including ECM and Community Supports, by incentivizing managed care plans (MCPs), in accordance with 42 CFR Section 438.6(b), to build appropriate and sustainable capacity; drive MCP delivery system investment in necessary delivery system infrastructure; bridge current silos across physical and behavioral health care service delivery; reduce health disparities and promote health equity; achieve improvements in quality performance; and encourage take-up of Community Supports.

Effective January 1, 2022, DHCS implemented the CalAIM Incentive Payment Program. DHCS designed the CalAIM Incentive Payment Program with input from various stakeholders in 2021 and initiated a second phase of design in 2022 based on lessons learned from CalAIM implementation activities. While CalAIM incentive payments are intended to complement and expand ECM and Community Supports, the incentive payments are also designed to incentivize quality and performance improvements and reporting in areas such as Long-Term Services and Supports and other cross-delivery system metrics.

Please submit questions about the Incentive Payment Program to: CalAIMECMILOS@dhcs.ca.gov. Additional program documents, including an All Plan Letter, is available at www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices.

[1] For more information on CalAIM, please see the CalAIM webpage at: https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx

2023 IPP Updates

1. **The IPP Program underwent significant updates in terms of program design and required measures. Can DHCS share more about the reasoning for these changes?**

DHCS made updates to the program design and strategic goals to ensure IPP continues to support all aspects of CalAIM, including extending implementation of IPP through June 2024. In evaluating CalAIM rollout to date, DHCS determined it would be most effective to refine the design principles and goals to fit the needs of plans, providers, members, and other stakeholders. This update includes an updated program timeline and measure set rooted in four streamlined program goals:

a. Member engagement and service delivery, including reaching new members;
b. Building sustainable infrastructure and capacity, including health information technology, workforce, and provider networks;
c. Promoting program quality, with measurable impacts on utilization; and
d. Creating equitable access for ECM Populations of Focus, including those becoming eligible in 2023 and 2024.

2. **What are the Priority Areas in the program measure set, and were they updated from Program Year 1 (CY 2022)?**

The measure set is organized into four Priority Areas:

1. Delivery System Infrastructure
2. ECM Provider Capacity Building
3. Community Supports Provider Capacity Building and MCP Take-Up
4. Quality and Emerging CalAIM Priorities

The fourth priority area is modified from Program Year 1 and includes several new measures for Program Years 2 and 3.

3. **What should MCPs expect in terms of measures in Priority Area 4 Quality and Emerging CalAIM Priorities?**

All measures in Priority Area 4 are mandatory beginning with Submission 3. Because Submission 3 is the first time MCPs will report on these measures, this submission will establish a baseline value and be scored on completeness. Priority Area 4 measures were developed based on extensive stakeholder and MCP feedback. Where possible, measure specifications align with HEDIS. Updated Priority Area 4 measures are designed to incentivize quality improvement for all Medi-Cal members and particularly those who

are ECM-eligible. DHCS developed a technical specifications guide to provide additional clarification to MCPs and support successful reporting on these new measures.

Program Design

1. **What submissions are required for IPP?**

There are six required submissions (with Submission 2 split into Submission 2-A and Submission 2-B). Submission information is outlined in the below table.

MCP Submission	Measurement Period	PY	MCP Submission Date
Submission 1	Not applicable	PY 1	January 31, 2022
Submission 2-A	January – June 2022	PY 1	September 1, 2022
Submission 2-B	July – December 2022	PY 1	March 1, 2023*
Submission 3	January – June 2023	PY 2	September 1, 2023
Submission 4	July – December 2023	PY 2	March 1, 2024
Submission 5	January – June 2024	PY 3	September 1, 2024

*NOTE: DHCS extended the due date for Submission 2B to March 15, 2023. This extension applied to all MCPs.

2. **How did DHCS design Submissions 3, 4 and 5?**

DHCS aimed to simplify and streamline the measure set for Submissions 3 – 5 based on stakeholder feedback and experiences with ECM, Community Supports, and other CalAIM initiatives to date. Submissions 3, 4 and 5 include select new measures that correspond to emerging priorities and CalAIM goals, including ECM Populations of Focus going live in 2023 and 2024. Most measures require only a quantitative response rather than a narrative. Scoring for most quantitative measures is based on a gap-filling calculation relative to baseline data. Submissions 3, 4 and 5 have an updated approach to quality measurement with fewer, more targeted measures. Given the expected upcoming changes to Medi-Cal MCP procurement in January 2024, Submissions 4 and 5 include measures focused on effective MCP transitions for affected counties.

3. **Are MCPs required to participate in this program in full or in any part?**

The incentive program is voluntary. MCPs will only be eligible to receive incentive payments by fulfilling all the requirements of the program.

4. **Can MCPs operating in counties where at least one MCP will be exiting or entering the Medi-Cal Managed Care market as of 1/1/2024 be able to participate in IPP?**

MCPs operating in a county with changes to the Medi-Cal Managed Care market on 1/1/2024 are eligible to participate in IPP for the measurement periods in which they are operating in the county. MCPs exiting the market on 12/31/2023 are eligible to participate in Submissions 1-4. Incoming MCPs entering the market on 1/1/2024 are eligible to participate in Submission 5 if they complete incoming MCP requirements, including a Needs Assessment and Gap-Filling Plan. Additional information on Submission 5 reporting requirements for incoming MCPs will be shared with the Submission 5 Reporting Templates.

5. **Which measures are optional and which are mandatory for the MCP to earn the payment in full?**

For Submission 1 and 2A, the Measure Set outlined which measures are mandatory and which are optional for each submission. To be eligible to receive full incentive payment allocations, MCPs must complete all the mandatory measures, and must complete the specified number of optional measures for each priority area.

Optional Measures are removed in Submissions 2B-5. MCPs must report on all measures in Submissions 2B-5 in order to be eligible to receive full incentive payment allocations.

Program Timeline

1. **What updates were made to the program timeline?**

The program timeline for IPP has been updated to (1) extend the performance period by six months, ending in June 2024 with final MCP submissions due in September 2024, and (2) divide the MCP reporting associated with Payment 2 into two distinct submissions, S2-A and S2-B. As in Program Year 1, each reporting period is six months long in Program Years 2 and 3. DHCS will make five IPP payments in total, with dollar amounts earned based on MCP submission scores.

2. **Can you provide clarification on timing and requirements for Submission 2B (S2B)?**

Submission 2B is due in March 2023. This submission will measure progress from July – December 2022. S2B is required for all MCPs to fully earn interim Payment 1 and earn Payment 2.

MCP Evaluation

1. **How will DHCS evaluate provider capacity, knowing that each contracted ECM and Community Supports provider may have different levels of capacity?**

DHCS will evaluate MCP capacity to serve the ECM and Community Supports populations based on their submission of the number of contracted providers and their submission of the anticipated number of providers needed to meet demand for each population of focus. MCPs will provide DHCS with this information via the numerator and denominator submission for the measure related to provider capacity for both ECM and Community Supports. MCPs are also required to submit an additional attachment describing their methodology for estimating anticipated need, as per the Reporting Template instructions. MCPs should use their Model of Care and eligibility criteria for Populations of Focus to guide this methodology, as well as collaborating with contracted providers to determine the full-time effort (FTE) needed to serve members.

Earning Payment

1. **Will partial payments for measures be awarded?**

The parameters for earning partial, full, or no payment for each measure are outlined in the Reporting Template for each submission. MCPs should refer to the applicable Reporting Template for a specific submission to determine how points are allocated and how payments may be earned.

Use of Funds

1. **Can the incentive payment only be used for ECM or Community Supports?**

DHCS does not direct how MCPs spend their earned incentive payments. In order to meet the goals of the program, achieve the measures, and support capacity and infrastructure development, DHCS anticipates participating MCPs will make strategic investments in, and direct appropriate resources to, ECM and Community Supports Providers, local partners, and other providers. MCPs can make ECM and Community

Supports Provider investments in any manner and using any resources deemed appropriate, including but not limited to, dollars earned from the incentive program.

DHCS expects MCPs to work closely with all applicable local partners including but not limited to, county social services, county behavioral health, public healthcare systems, county/local public health jurisdictions, CBOs, correctional partners, housing continuum, and others, in their efforts to achieve the measures.

2. **Will DHCS require MCPs to share a minimum percentage of incentive funding with providers?**

No, this is not federally permissible in this context. However, for the successful implementation of CalAIM, including ECM and Community Supports, MCPs will need to make strategic investments in, and direct appropriate resources to, ECM and Community Supports Providers, local partners, and other providers. DHCS expects MCPs to work closely with all applicable local partners including, but not limited to, county social services, county behavioral health, public healthcare systems, county/local public health jurisdictions, community based organizations (CBOs), correctional partners, housing continuum and others in their efforts to achieve the measures. In order to meet the goals of the program and achieve the measures, DHCS anticipates participating MCPs will maximize the investment and flow of incentive funding to ECM, Community Supports, and other providers to support capacity building and infrastructure development.

Data Collection and Data Sources

1. **Will DHCS share or reference code sets (i.e. HEDIS) that will be used for MCPs' denominator identification (CINs) and DHCS's numerator calculations?**

DHCS has developed a technical specifications document to provide MCPs with guidance on data reporting and calculations. TA is also available for questions related to quality measures.

Terms and Definitions

1. **For measures that refer to a "care team," how is this term defined?**

MCPs should consider a definition for "care team" that includes an interdisciplinary team needed to appropriately provide care for the Member based on the Member's level of need and determine which providers are necessary as part of the Member's care team.

2. **For measures that refer to "closed-loop referral systems," how is this term defined?**

Closed-loop referrals are defined as people, processes, and technologies that are deployed to coordinate and refer Members to available community resources and follow-up to verify if services were rendered. A closed-loop referral system should describe processes that ensure the referring and referred-to providers and MCPs receives information they need to serve a referred Member and to validate if and when the referred service was delivered.

Plan Delegates/Subcontracted Plans

1. **For counties where Managed Care Plans subcontract with other MCPs to provide Medi-Cal services, what is the expectation for sub-contracted plans or sub-contracted, fully capitated public healthcare systems, such as in Los Angeles, San Francisco, and Santa Clara?**

Each Prime MCP is responsible for their subcontractors, including coordination, reporting and oversight. MCPs must include data on their entire network when responding to measures, including their subcontracted networks. This includes, but is not limited to, reporting on utilization, referrals, program eligibility, provider contracts, and activities conducted by the MCP. When responding to narrative measures, Prime MCPs should include a discussion about any coordination between the Prime MCP and subcontracted MCP(s).

Delegating Activities to Providers

1. **Can MCPs delegate the activities and deliverables for each milestone to providers, and therefore have the incentive earned at the provider level?**

Incentives are earned, or not earned, at the MCP level. The MCP is responsible for ensuring the activities are completed and reported to DHCS to earn their full incentive payment. DHCS recognizes the importance of MCPs delegating activities, such as staff training, to providers to support capacity building at the provider-level.